General Assembly

Raised Bill No. 1022

January Session, 2009

LCO No. **3954**

03954_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING GUARANTEED ISSUE FOR INDIVIDUAL HEALTH PLANS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-481 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) Each insurance company, health care center, fraternal benefit society, hospital service corporation or medical service corporation that delivers, issues for delivery, renews, amends or continues in this state an individual health insurance policy or contract shall offer such policy or contract on a guaranteed issue basis.

[(a)**]** (b) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. The commissioner shall adopt regulations, in accordance with chapter 54, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply

with the requirements of law, or if it contains a provision or provisions **[**which**]** that are unfair or deceptive or **[**which**]** that encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer **[**which**]** that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

[(b)**]** (c) No rate filed under the provisions of subsection **[**(a)**]** (b) of this section shall be effective until the expiration of thirty days after it has been filed or unless sooner approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with chapter 54, to prescribe standards to insure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards, except that no rate filed under the provisions of subsection **[**(a)**]** (b) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.

[(c)**]** (d) No insurance company, fraternal benefit society, hospital service corporation **[**,**]** or medical service corporation, health care center or other entity **[**which**]** that delivers, **[**or**]** issues for delivery, renews, amends or continues in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

[(d)**]** (e) Rates on a particular policy form **[**will**]** shall not be deemed excessive if the insurer has filed a loss ratio guarantee with the Insurance Commissioner **[**which**]** that meets the requirements of subsection **[**(e)**]** (f) of this section provided (1) the form of such loss ratio guarantee has been explicitly approved by the Insurance Commissioner, and (2) the current expected lifetime loss ratio is not more than five per cent less than the filed lifetime loss ratio as certified by an actuary. The insurer shall withdraw the policy form if the commissioner determines that the lifetime loss ratio will not be met. Rates **[**also will**]** shall not be deemed excessive if the insurer complies with the terms of the loss ratio guarantee. The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to assure that the use of a loss ratio guarantee does not constitute an unfair practice.

[(e)**]** (f) Premium rates shall be deemed approved upon filing with the Insurance Commissioner if the filing is accompanied by a loss ratio guarantee. The loss ratio guarantee shall be in writing, signed by an officer of the insurer, and shall contain as a minimum the following:

(1) A recitation of the anticipated lifetime and durational target loss ratios contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(2) A guarantee that the actual Connecticut loss ratios for the experience period in which the new rates take effect and for each experience period thereafter until any new rates are filed will meet or exceed the loss ratios referred to in subdivision (1) of this subsection. If the annual earned premium volume in Connecticut under the particular policy form is less than one million dollars and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nation-wide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars, the experience period will be extended until the end of the calendar year in which one million dollars of earned premium is attained;

(3) A guarantee that the actual Connecticut or nation-wide loss ratio results, as the case may be, for the experience period at issue will be independently audited by a certified public accountant or a member of the American Academy of Actuaries at the insurer's expense. The audit shall be done in the second quarter of the year following the end of the experience period and the audited results **[**must**]** shall be reported to the Insurance Commissioner not later than June thirtieth following the end of the experience period;

(4) A guarantee that affected Connecticut policyholders will be issued a proportional refund, which **[**will**]** shall be based on the premiums earned, of the amount necessary to bring the actual loss ratio up to the anticipated loss ratio referred to in subdivision (1) of this subsection. If nation-wide loss ratios are used, the total amount refunded in Connecticut shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned from all Connecticut policyholders who will receive refunds and divided by the total premium earned in all states on the policy form. The refund shall be made to all Connecticut policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal two dollars or more. The refund shall include interest, at six per cent, from the end of the experience period until the date of payment. Payment shall be made during the third quarter of the year following the experience period for which a refund is determined to be due;

(5) A guarantee that refunds less than two dollars **[**will**]** shall be aggregated by the insurer. The insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center;

(6) A guarantee that the insurer, if directed by the Insurance Commissioner, shall withdraw the policy form and cease the issuance of new policies under the form in this state if the applicable loss ratio

exceeds the durational target loss ratio for the experience period by more than twenty per cent, provided the calculations are based on at least two thousand policyholder-years of experience either in Connecticut or nation-wide.

[(f)**]** (g) For the purposes of this section:

(1) "Loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations; and

(2) "Experience period" means the calendar year for which a loss ratio guarantee is calculated.

[(g)**]** (h) Nothing in this chapter shall preclude the issuance of an individual health insurance policy **[**which**]** that includes an optional life insurance rider, provided the optional life insurance rider **[**must**]** shall be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

[(h)**]** (i) No insurance company, fraternal benefit society, hospital service corporation **[**,**]** or medical service corporation **[**, health care center or other entity which**]** that delivers, issues for delivery, amends, renews or continues an individual health insurance policy in this state **[**on or after October 1, 2003, may**]** shall: (1) **[**move**]** Move an insured individual from a standard underwriting classification to a substandard underwriting classification after the policy is issued; or (2) increase premium rates due to the claim experience or health status of an individual who is insured under the policy, except that the entity may increase premium rates for all individuals in an underwriting classification due to the claim experience or health status of the underwriting classification as a whole.

Sec. 2. Section 38a-182 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) An agreement issued by a health care center governed by sections 38a-175 to 38a-192, inclusive, as amended by this act, may be issued for health care or the costs thereof to a subscriber, to a subscriber and spouse, to a subscriber and family, to a subscriber and dependent or dependents related by blood, marriage or adoption or to a subscriber and ward. Each such health care center that delivers, issues for delivery, renews, amends or continues in this state such agreement shall offer such agreement on a guaranteed issue basis. Such agreement or evidence of coverage document shall be in writing and a copy thereof furnished to the group contract holder or individual contract holder, as appropriate.

(b) Each such agreement shall contain the following provisions: (1) Name and address of the health care center; (2) eligibility requirements; (3) a statement of copayments, deductibles or other out-of-pocket expenses payment payable by the subscriber; (4) a statement of the nature of the health care services or benefits to be furnished and the period during which they will be furnished, and, if there are any services or benefits to be excepted, a detailed statement of such exceptions provided that such services or benefits to be furnished conform at a minimum to the requirements of the Federal Health Maintenance Organization Act; (5) a statement of terms and conditions upon which the agreement may be cancelled or otherwise terminated at the option of either party; (6) claims procedures; (7) enrollee grievance procedures; (8) continuation of coverage; (9) conversion; (10) extension of benefits, if any; (11) subrogation, if any; (12) description of the service area, out-of-area benefits and services, if any; (13) a statement of the amount payable to the health care center by the subscriber and by others on his behalf and the manner in which such amount is payable; (14) a statement that the agreement includes the endorsement thereon and attached papers, if any, and contains the entire agreement; (15) a statement that no statement by the subscriber in his application for an agreement shall void the agreement or be used

in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such agreement; and (16) a statement of the period of grace which will be allowed the subscriber for making any payment due under the agreement, which period shall not be less than ten days.

(c) Every subscriber shall receive an evidence of coverage from the group contract holder or the health care center. The evidence of coverage shall not contain provisions or statements **[**which**]** that are unfair, inequitable, misleading, deceptive or **[**which**]** that encourage misrepresentation. The evidence of coverage shall contain a clear statement of the provisions set forth in subdivisions (1) to (12), inclusive, of subsection (b) of this section.

Sec. 3. Section 38a-183 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) A health care center governed by sections 38a-175 to 38a-192, inclusive, as amended by this act, shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the commissioner's approval thereof. The commissioner may refuse such approval if he finds such amounts to be excessive, inadequate or discriminatory. Each such health care center shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a copy of such agreement or agreements, including all riders and endorsements thereon, and until the commissioner's approval thereof has been obtained. The commissioner shall, within a reasonable time after the filing of any request for an approval of the amounts to be paid, any agreement or any form, notify the health care center of either his approval or disapproval thereof.

(b) A health care center may establish rates of payment by any method permitted by the Federal Health Maintenance Organization Act and the regulations adopted thereunder from time to time unless otherwise determined by the commissioner by regulation, except that

no such health care center shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

(c) Each such health care center may include as a component of its rate a sum up to ten per cent of such rate to be used for the objects and purposes set forth in section 38a-184. An amount not exceeding ten per cent of the annual net premium income of such center may be set aside annually as a capital reserve fund and may be accumulated from year to year by such health care center, to be expended for the objects and purposes as set forth and in accordance with said section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2010*	38a-481
Sec. 2	*January 1, 2010*	38a-182
Sec. 3	*January 1, 2010*	38a-183

Statement of Purpose:

To require individual health insurance policies and plans and subscriber agreements to be offered on a guaranteed issue basis, and to make conforming changes.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]